

**Meeting Minutes**  
**Health Information Technology Council Meeting**

January 13, 2014  
3:30 – 5:00 P.M.

**One Ashburton Place, 21<sup>th</sup> floor Matta Conference Room  
Boston, MA**

## Meeting Attendees

Name	Organization	Attended
John Polanowicz	<i>(Chair) Secretary of the Executive Office of Health and Human Services</i>	Yes
Manu Tandon	<i>(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator</i>	Yes
William Oates	<i>Chief Information Officer, Commonwealth of Massachusetts</i>	No
David Seltz	<i>Executive Director of Health Policy Commission</i>	Yes
Aron Boros	<i>Executive Director of Massachusetts Center for Health Information and Analysis</i>	No
Laurance Stuntz	<i>Director, Massachusetts eHealth Institute</i>	Yes
Eric Nakajima	<i>Assistant Secretary for Innovation Policy in Housing and Economic Development</i>	Yes
Patricia Hopkins MD	<i>Representative from a small Physician group Practice Rheumatology &amp; Internal Medicine Doctor (Private Practice)</i>	Yes
Meg Aranow	<i>Senior Research Director, The Advisory Board Company</i>	Yes
Deborah Adair	<i>Director of Health Information Services/Privacy Officer, Massachusetts General Hospital</i>	Yes
John Halamka, MD	<i>Chief Information officer, Beth Israel Deaconess Medical Center</i>	Yes
Normand Deschene	<i>President and Chief Executive Officer , Lowell General Hospital</i>	No
Jay Breines	<i>Executive Director, Holyoke Health Center</i>	Yes
Robert Driscoll	<i>Chief Operations Officer, Salter Healthcare</i>	Yes
Michael Lee, MD	<i>Director of clinical Informatics, Atrius Health</i>	Yes
Margie Sipe, RN	<i>Performance Improvement Consultant, Massachusetts Hospital Association (MHA)</i>	Yes
Steven Fox	<i>Vice President, Network Management and Communications, Blue Cross Blue Shield MA</i>	yes
Larry Garber, MD	<i>Medical Director of Informatics, Reliant Medical Group</i>	Yes
Karen Bell, MD	<i>Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED</i>	Yes
Kristin Madison	<i>Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences</i>	Yes
Daniel Mumbauer	<i>President &amp; CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA</i>	Yes
Kristin Thorn	<i>Acting Director of Medicaid</i>	Yes

## Guest

Name	Organization
Robert McDevitt	EOHHS
Nick Welch	EOHHS
Kathleen Snyder	EOHHS
Claudia Boldman	ITD

Sean Kennedy	MeHI
Jennifer Monahan	MAeHC
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Carol Jeffery	MAeHC
Lisa Fenichel	Consultant
Amy Caron	EOHHS
Adrian Gropper	MMS and PPR
James Murray	CVS
Darrel Harmer	EOHHS
David Smith	MHA
David Bachard	Neqca
Sarah Moore	Tufts MC
Nelson Gagnon	Mass Hiway
Paul Quigley	Cornerstone Healthcare Consulting
Charles Paradise	Federal Litigant

## Meeting called to order – minutes approved

The meeting was called to order by Manu Tandon at 3:32 P.M.

The Council reviewed minutes of the December 9, 2013 HIT Council meeting. The minutes were approved as written.

### Discussion Item 1: Client Implementation Update (Slides 3-18)

*See slides 3-18 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.*

#### **Jim Murray, Vice President Information Technology, CVS Care Mark, presented on CVS Caremark's MinuteClinic HIway Connection**

*(Slide 3-4) Retail Clinic Integration- Introduction.*

*(Slide 5) CVS Caremark- A Pharmacy Innovation Company- CVS is more than just a retail pharmacy. A list of the company's other ventures was provided.*

*(Slide 6- ) MinuteClinic Model & Services: Core Beliefs and Standards- MinuteClinic strives to lessen the financial, access and convenience barriers while providing on-demand basic primary care services.*

*(Slide 7) Largest and Fastest Growing Retail Clinic- MinuteClinic employs the largest number of Nurse Practitioners (NP's) in the country; over 2,400. Half of MinuteClinic patients do not have a primary care physician.*

*(Slide 8) MinuteClinic Location Map-* A map of national MinuteClinic locations was provided. Since 2011 over 350 clinics were added, totaling around 800.

*(Slide 9) MinuteClinic and Coverage Expansion-* Roughly 83- 85% of patients seen at MinuteClinic are using 3<sup>rd</sup> party coverage-clinics are also enrolled with Medicaid. For those that pay out of pocket, CVS tries keep prices transparent and affordable.

*(Slide 10) Comparing Cost and Quality of Treating Common Illnesses across Medical Settings-* The results of a 2009 study demonstrated that MinuteClinic provides quality care at a lower cost than in other medical settings. Many organizations argue that CVS is just driving traffic into the pharmacy, but the pharmacy costs, indicated in red, are validated by the study-in line or below a physician practice.

*(Slide 11) Health Systems Affiliations-collaborating around the U.S. –* The clinical affiliations are less of a business relationship and more of a partnership. For example, the NPs in Los Angeles work under the supervision of University of California, Los Angeles (UCLA) doctors. In Worcester they work under the supervision of doctors at UMass Memorial. MinuteClinic links the medical record systems to better manage patients. They work with wellness programs to better manage at risk or high risk patients by using MinuteClinic as supplemental healthcare.

*(Slide 12) MinuteClinic and Massachusetts-* There are currently 47 clinics in MA, with a 40% volume growth. The next area of growth in the state will be in Western MA.

*(Slide 13) Integration Workflow Overview-* MinuteClinic goal is to collaborate with as many organizations as possible for greater continuity of care. Right now MinuteClinic supports a number of different connection methods to increase participation. There are some connection standards in place, but everyone has a different way of doing things.

The diagram depicts the basic workflow of: The NP looks for basic information on the patient (e.g. medications and allergies), provides and documents care. The Clinic then sends the visit summary to the primary care provider notifying them that their patient was at MinuteClinic. It was pointed out that the HIway could be used to receive information from providers for use in the first step (looking up basic information on the patient), as well as sending out CCD after the care has been given to the patient.

*(Slide 14) MinuteClinic and UMASS Technical Design-* The design documentation from UMass Memorial was presented. The diagram is meant to show the complexities and the amount of work UMass had to do to make these connections work. One of the more interesting things about the design is that records will be coming from all over the country because MinuteClinic is on a central database.

*(Slide 15) Lessons Learned-* A lot of people think this is easy to do and many affiliate organizations have their own way of doing things. The lack of standards added work- whether it is HISP to HISP or a web service, the more connection types MinuteClinic can support will increase the program's success.

*(Slide 16) MinuteClinic and the Mass HIway-* They are close to completing the final end-to-end testing and planning to have pilot practices on the HIway in February. Connectivity testing is also underway

from UMass to the HIway. It is anticipated that CVS will be the first organization to begin transacting with the HIway under a “HISP to HISP” connection.

*(Slide 17) MinuteClinic and the Mass HIway Cont.-* Once the HISP is up and running MinuteClinic will look to collaborate with other organizations and leverage the MA HIway in a more robust way. MinuteClinic continues to expand their scope of services which will help generate more volume for the HIway. Throughout the country, a new clinic is opened every other day.

*(Slide 18) Thank you!-* Participation in the HIway has been crucial and important for CVS. MA is one of the most advanced HIE’s in the country so it has been a pleasure to work together.

- Question (John Halamka): There was a push to move to Allscripts, what is the status of EHR choice and what standards are you using?
  - Answer (Jim Murray): Still on the propriety EHR, but have put a clinical integration engine in place which takes the messages from the primary system and puts them into the format requested by the receiver; supports both CCR and CCD to allow for flexibility.
- Question (John Halamka): This makes sense for push, but now that we are demonstrating phase 2 pull, how might you use your integration engine to request records?
  - Answer (Jim Murray): We see four million patients a year, most of which are walk-ins. Almost all patients interact with a kiosk at check in which gathers enough information to launch a query, gather consent, and send an order to the physician.
- Comment (John Halamka): We demonstrated pull, as well as push-push, we would be interested to see what you are doing to see how they align.
- Question (Larry Garber): The Continuity of Care Document (CCD) typically does not have a progress note, do you include that?
  - Answer (Jim Murray): Yes, we are putting the progress note in there. I cannot tell you where exactly that tag is going, but overall it has been received very well. Some are looking at MinuteClinic data to manage hypertension; they want those discrete values to have a heads up on a rising blood pressures.
- Question (Mike Lee): Do you have examples of where you are not just using the clinic for Acute Care? Chronic disease management for example.
  - Answer (Jim Murray): Yes, we are involved in a number of different monitoring programs. The NP is not providing initial diagnosis, but it allows the patient to utilize the MinuteClinic at their convenience. The clinic will flag data so they know the patient is part of this program. MinuteClinic is open on weekends making it convenient for employees to satisfy insurance and/or employer requests for things like physicals. The patient may be checking HBA1C for example – under affiliation, they can do this on Sunday morning instead of taking time off from work.
- Question (Karen Bell): Behavioral health and substance abuse rules vary from state to state. How do you deal with that complexity?

- Answer (Jim Murray): We enter into these arrangements and adhere to the restrictions of the organization. If we ask for medication lists, the organization would not disclose the information if it were against state law.
- Question (Larry Garber): Are you reporting for public health – for example flu shots to immunization registry?
  - Answer (Jim Murray): In the 28 states we operate in, we are reporting in every state where it is required + 5 more. Our goal is 100% reporting to registries.
- Question (Laurance Stuntz): If someone is not affiliated with UMass as a patient, do they need to have a clinical relationship with MinuteClinic as well as the provider?
  - Answer (Jim Murray): They do not need to have a relationship, but we have never done an exchange without one.
- Question (Laurance Stuntz): How would that work?
  - Answer (Jim Murray): We are getting per incident consent from patients.
- Question (Meg Aranow): Have you looked at any data in MA to analyze the traffic? How many visits are acute for example?
  - Answer (Jim Murray): We do not have specific numbers in MA, however nationwide it is about 70% on the acute side, but that is heavily weighted by the flu season, versus summer camp or sports physicals. There is also an increase in screenings for employers or insurance companies.
- Question (Laurance Stuntz): You will be able to do sports clinics in MA?
  - Answer (Jim Murray): I think so.
- Comment (Secretary Polanowicz): I believe the regulations are out there, for those people that do not know, through The Department of Public Health (DPH) there is a whole new set of limited services. We took feedback from providers, the Medical Society (MMS), and the Hospital Association (MAHA), felt it was important to ensure that the patient physician relationship was not compromised. There was concern around continuity of care around pediatric patients. CVS was great to work with on this; there is a good balance in terms of expansion of services while maintaining effective primary care relationships.
- Comment (Jim Murray): MinuteClinic is not trying to disrupt this relationship, instead we are looking to be a supplemental location of care, and parents with children often receive last minute “I need this for camp...tomorrow” requests, MinuteClinic can provide those services without an appointment, at the last minute.

## **Discussion Item 2: Advisory Group Update (Slides 19-21)**

*See slides 19-21 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.*

**Advisory group updates were presented by Micky Tripathi, CEO of the Massachusetts eHealth Collaborative (MAeHC).**

*(Slides 20-21) Advisory Group Update-* The Technology and Legal and Policy Advisory Groups met last month. Both grappled with the same issues around scalability. A large number of providers are

connecting through a HISP, eClinical Works (eCW) for example is requiring a connection through their network, so now there is a need for technical agreements. By the end of the month testing with eCW and Surescripts should be completed.

Chapter 224 has policy constraints around participation agreements- a member of a HISP must sign a contract with the HIway, separate from their contract with the HISP. In some ways the EHR vendors are familiar with those connections (e.g. lab interfaces or electronic prescribing), but in this case we are not paying them.

There was discussion around provider to provider scaling in terms of uptake. The particular use case is around patients receiving treatment in different states- what if a provider in Florida has a patient spending summer in MA and would like to fast track the membership into the MA HIway. It depends on how the physician is connected and what EHR they are using. If the physician is already on eCW, they just need to sign the HIway participation agreement. If not using eCW there is more work to do from an integration perspective. Right now we do not have solid answers, but these are the issues we are trying to tackle.

- Comment (John Halamka): There is a nationwide effort underway with DirectTrust to deal with some of this. The problem is that it is in the early days. They are now offering a temporary trust bundle of those going through certification. We probably want to be fast followers here.
- Comment (Micky Tripathi): What we are seeing from vendors like eCW, there is a lot of push to get practices to join, but then when you move to implement, the vendor is not ready. For eCW they have said we are the first production test they will have had. There continues to be forward progress, scaling issues will be ones we still need to answer.

### **Discussion Item 3: Mass HIway Update- Outreach & Sales Update – Last Mile Program (Slides 22-26)**

*See slides 22-26 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.*

#### **Mass HIway Update presented by Massachusetts eHealth Institute (MeHI) Health Information Exchange Director Sean Kennedy.**

*(Slide 23) Program Evaluation Update-* The 2012 evaluation is complete and the 2013 evaluation is underway (due March 7<sup>th</sup>). If anyone is interested in participating in evaluation interviews please contact Sean.

*(Slide 24) Last Mile Program Transition Planning-* The ONC grant will be over on February 7<sup>th</sup>, with a 90 day period to close out the grant. The quarterly progress report is due January 31<sup>st</sup>, the final program performance report is due on February 7<sup>th</sup>, and the program evaluation is due on March 7<sup>th</sup>.

There is a big effort underway right now for the Last Mile transition planning. MeHI will likely assist with grant management, education, adoption and innovation post grant. There are over 100 organizations in the pipeline right now.

- Question (Steve Fox): Do you have any documentation of where prospects are and why?
  - Answer (Sean Kennedy): There are some Salesforce notes, but there is not a way to pull a report right now.
- Question (John Halamka): The new Office of the National Coordinator (ONC) starts today. Before he left, Farzad said to end all grant programs. Are you seeing any signals that there might be a change in direction?
  - Answer (Sean Kennedy): We have long asked for an extension and there will be money left on the table at the end of the grant. ONC made it clear that they will not be extending the grant and we have not heard anything different so far.
- Comment (Laurance Stuntz): The Regional Extension Center (REC) monies go back to the General Fund, while the HIE money will go back to ONC. After sweeping up the leftover monies they could potentially look to reallocate to specific innovations. There is an ONC annual meeting next week, it will be interesting to see what they say.
- Question (Secretary Polanowicz): Do you know how many Acute Care hospitals are in the process of joining the HIE?
  - Answer (Sean Kennedy): Unsure right now.
  - Follow-up (Manu Tandon): We will bring that information to the next meeting.
- Comment (Mike Lee): The challenge is that if a hospital is on, but the providers are not, there will be no one to talk to.
- Comment (David Seltz): The Health Policy Commission just announced grants for community hospitals and a number of hospitals applied to connect their community providers to the HIE so that they can facilitate the talking.
- Comment (Secretary Polanowicz): The first funds will go out next month.
- Comment (Laurance Stuntz): Some had large goals, and others did not.
- Question (Manu Tandon): Are they at the point where they can connect?
  - Answer (David Seltz): They are in a contract revision phase right now- looking to create the most effective plan for the funds.
  - Answer (Laurance Stuntz): Some are already connected (Baystate, Harrington).

*(Slide 25) Hlway Interface Grants: Progress-* The council was provided with a rundown on grantee milestones. McKesson is the only one left to sign on. MeHI recently adjusted the rules for milestone 3; grantees will be asked to complete just one connectivity test. A couple are close to reaching milestone 4.

*(Slide 26) Hlway Implementation Grants: Progress Cont. -* A grant amendment to extend milestone dates was issued. Cooley Dickenson is about to come on. Milestone 2, Hlway directory uploads, has been a challenge. All grantees hope to meet milestone 3 before the next Health Information Technology Council Meeting (HITC).

February 6<sup>th</sup>: A Rally! A “Hlway Transact-athon.” MEHI is encouraging participants, in test or production, to send a transaction using the Hlway and then tweet about it. This is an opportunity for hospitals and other organization to showcase efforts.

**Implementation and Support Update presented by Manu Tandon, Executive Office of Health and Human Services (EOHHS) Secretariat Chief Information Officer and Massachusetts Health IT Coordinator. (Slides 28-33).**

*(Slide 28) HIway Phase 2 Go-live Event*-The Phase 2 event was a success. EOHHS is currently working with Tufts, Beth Israel Deaconess, Atrius and Holyoke to start getting their ADT messages. The value of Phase 2 services (Query/retrieve & Relationship Listing Service) is really when we start to gather that information.

Generally the press covered the event broadly and it was well received, but some of the stories highlighted the complexities-particularly around where the data is held. There were a number of responses online to the Boston Globe article. EOHHS is now in the process of refining the next set of artifacts in terms of how folks can use the services, part of that is setting up some goals for 2014.

- Comment (John Halamka): Looking at the work ahead, it isn't so much technical. Kathleen has been working with BIDMC for a long time to assure that there is meaningful consent, but the technology is ready.
- Question (Manu Tandon): Can we take historical ADTs?
  - Answer (John Halamka): This is a question for the legal team. A large number of signatures have been collected, but the current consent form does not name the HIway.
- Comment (Deborah Adair): For phase 2 we are going to have to start from square one to incorporate the three new elements of what they really are consenting to in the exchange.
- Comment (Mike Lee): Early on we debated sending out a group message across the portal, allowing patients to consent there rather than person to person. We may want to think about the dual factor authentication if we cannot verify where the request has come from. If you take my password you can query anyone's record in the system. We created an internal safeguard, if you try to get on the network, you must respond on your cell phone to login. After watching the event, when you look at the Globe comments, most are about who is going to have access.
- Comment (Larry Garber): I second what Mike said. Retrospectively, if we already received the signatures, why does it specifically need to say the HIway?
- Comment (Deborah Adair): We want patients to understand that there will be data on the HIway- their name will be in a registry. It has been a challenge making the language patient friendly.
- Comment (Larry Garber): The only ones that can see the information are the ones in the directory.
- Comment (Mike Lee): It is complicated to explain. I can assume as a tax payer the state already has my name and address. Routing this information through the HIway doesn't mean that this is different and new.
- Question (Secretary Polanowicz): Is there a way to do this so everyone doesn't have a different approach?
  - Answer (Deborah Adair): This is being discussed with the Legal and Policy Advisory Group. The current thought was not to dictate a standard form.

- Comment (Secretary Polanowicz): With 55 organizations signed up you have early adopters to help get this right. Once the rest show up they should be able to take advantage of what we have learned.
- Comment (Jay Breines): It seems to be a basic issue. If you have a very fragile patient, or a not very literate patient, how do they consent to something they do not understand? The person who may benefit most may be the one that does not understand. There needs to be a balance between what is consent, versus what is beneficial.
- Comment (Deborah Adair): We are working on a document that is pretty basic in terms of how to explain that to a patient, in low level language.
- Comment (John Halamka): During an interview about the phase 2 event a listener asked an interesting patient related question- What if an organization like Partners recorded some of my information incorrectly, then sends it to another organization, and another, creating a domino of inaccurate information. When and if the information is fixed, will it go back through those organizations to be corrected?
- Comment (Mike Lee): It would help us more to have a second page that says "Are there other institutions that you would like us to send this consent information to?" If that patient were to check off where they have records, it would take some work on the hospital end to keep that information, but they could fax the information to other providers in their care team. If they come to Reliant, but have been seen at St. Vincent frequently, it would be more efficient. The fear is that there will be so little useful information people may give up on it too early.
- Question (Patricia Hopkins): Could you have a universal consent the patient would opt into?
  - Answer (Mike Lee): Yes, this is an opt-in. If you are saying you want to say yes here, would you also want to say yes at others.

*(Slide 29) December Activity-* A list of organizations that went live in December was provided. There are currently 28 organizations live on the Hlway, 35 organizations in production and 63 connections overall.

*(Slide 30) New Participation Agreements-* Two new organizations have signed participation agreements in December- Beth Israel Deaconess/ Milton Hospital and Cambridge Health Alliance.

*(Slide 31) HISP to HISP Connectivity-* EOHHS is actively testing with Surescripts, eCW and SES and expect all three to be completed by the end of January. The next vendors targeted are listed on the slide. EOHHS will continue to have a team focused solely on HISP connectivity.

- Comment (John Halamka): NexJ will be the first patient facing HISP. It is almost like a doctor patient social networking application that allows users to develop a shared care plan. Patients and their families can create a plan and send it back using the Hlway. Use cases are still being defined, but it is very interesting and innovative.

*(Slide 32) Transaction Update –* 119,767 transactions were exchanged in December- 1,884,260 cumulative transactions. The deadline for migration from the Virtual Gateway to the Hlway for Immunization submissions was extended from 12/31/2013 to 2/28/2014.

- Comment (Secretary Polanowicz): Next time could we have a 13 month rolling timeline to compare last year and this year, it is hard to see program progress with these numbers.

*(Slide 33) HIway Development Timeline-* The cancer registry node was pushed back to March. The go-live for Phase 2, release 1 is complete. The Lead Poisoning Node will go-live in March and the Phase 2, release 2, will go live in the February-April 2014 timeframe. There will be a more detailed plan for the next Council meeting.

#### **Discussion Item 4: Wrap-Up (Slides 34-35)**

*See slides 34-35 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.*

#### **Wrap-up presented by Manu Tandon**

The schedule for the 2014 HIT Council Meetings was provided.

- ~~January 13~~
- February 3
- March 3
- April 7
- May 5
- June 9
- July 7
- August 4
- September 8
- October 6
- November 3
- December 8

*\* All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21<sup>th</sup> floor, in the Matta Conference Room.*

The Next HIT Council Meeting is scheduled for **February 3, 2014** from 3:30pm-5pm at One Ashburton Place, 21<sup>th</sup> floor, in the Matta Conference Room.

The HIT Council meeting was adjourned at 4:58 P.M.